



**“COST PLUS”
REIMBURSEMENT REQUEST**

Group Name: _____

Contract Number: _____

NAME OF EMPLOYEE	IDENTIFICATION NUMBER	AMOUNT CLAIMED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pursuant to our special reimbursement agreement, please reimburse the indicated amount(s) to the above-mentioned employee(s).

Group Administrator’s Signature: _____

Date: _____

Please forward, clearly marked “Confidential”, to the attention of Mrs. Sylvie Robitaille or Mrs. Andréanne Drouin, La Capitale Insurance and Financial Services.

N.B.: This form may be reproduced if needed.